

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16059

State File No.

FILED APR 23 1953

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 3763

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1313 Carr St	
3. NAME OF DECEASED (Type or Print) a. (First) Alonzo b. (Middle) c. (Last) Norman		4. DATE OF DEATH (Month) (Day) (Year) April 8 1953	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 1, 18, 1882
9. AGE (In years last birthday) 70		10. AGE (In years last birthday) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Nashville, Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Harvey Norman		13b. MOTHER'S MAIDEN NAME Elizabeth McGregory	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 492-16-1265		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Johnnie Mae Wilkerson 5615 S. Michigan Chicago, Ill.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Esophageal Varices Antecedent Causes Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Massive G. I. Hemorrhage Interval between onset and death Undet. Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4509		22. I hereby certify that I attended the deceased from 3-31, 19 53, to 4-8, 19 53, that I last saw the deceased alive on 4-8, 19 53, and that death occurred at 10:15 a.m., from the causes and on the date stated above.	
23a. SIGNATURE Edna Brooks M. D. O.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 4-9-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE April 10, 1952		24c. NAME OF CEMETERY OR CREMATORY Oak Dale	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Bell Ave.	
DATE REC'D BY LOCAL REG. APR 10 1953		REGISTRAR'S SIGNATURE J. C. Smith M.D. (Licensed Embalmer's Statement on Reverse Side)	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

Licensed Embalmer No. 2698

P. O. Address 2749 Chandler

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.